## Iowa Department of Public Health Master Index Card

Patient's Name:			SSN:		Date of Birth:	Gender:	
Parent/Guardian:			Home Phone:	 Biı	th State/Country:		
Address:			Cell Phone:  Medicaid #:		other's Maiden Name:		
E-mail:							
Ethnicity: ☐ Hispanic or L Race: ☐ American Indian Medical Notes/Allergies: _ This child qualifies for the VFC pr	atino C /Alaska Na		nrolled⊡Nl-Has No Insur	ance∏Al/AN-Am. Ind/AK N			
Vaccine	Date Given	Client / Parent / Guardian Signature *	Health Care Provider	Dosage / Route / Site	Manufacturer / Lot #	VIS Form & Date	
Diphtheria, Tetanus, Pertussis I	DTaP/Tdap/D	TP/DT/Td			•		
· · · · · · · · · · · · · · · · · · ·							
Polio IPV/OPV		<u> </u>	1	1	1		
Macalaa Mumma Duballa MMD					1		
Measles, Mumps, Rubella MMR		I	Τ	1	T		
					+		
Haemophilus influenzae type b	Hih	<u> </u>			<u> </u>		
	12	T					
Hepatitis B	-		•	•	•		

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Patient's Name:				Date of Birth: Physician:					
Vaccine	Date	Given	Client / Parent / Gu	ıardian Si	gnature *	Health Care Provider	Dosage / Route / Site	Manufacturer / Lot #	VIS Form & Date
Varicella Chicken Pox/Shir									
Pneumococcal PCV/PPV									
Maningage and MCV/4/MDS	-\								
Meningococcal MCV4/MPS	V4							ı	1
Hepatitis A	<u> </u>							<u> </u>	
								I	
Rotavirus									
HPV									
Influenza	-		Г			1		İ	1
Other	1		<u> </u>			<u> </u>	l	1	<u> </u>
Guiei	1							Ι	
Health Care Provider	Initials	Health	n Care Provider	Initials	Notes	/ Comments:	<u> </u>	1	
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